IDAHO MEDICAID QUALITY ASSURANCE/IMPROVEMENT PLAN FOR THE HEALTHY CONNECTIONS (PCCM) WAIVER - 2004

PURPOSE

The purpose of the Healthy Connections Quality Assurance/Improvement plan is to improve the Medicaid delivery system by meeting the following objectives:

1. Ensure access to health care for Medicaid participants;
2. Provide health education to Medicaid participants;
3. Promote continuity of care for Medicaid participants;
4. Strengthen the patient/physician relationship between Medicaid participants and Idaho Medicaid providers;
5. Achieve cost efficiencies for services provided by the Idaho Medicaid program;
6. Prevent unnecessary and inappropriate utilization of Medicaid services; and
7. Reduce duplication of services provided by the Idaho Medicaid program.

The basic concept of the program, as outlined in the 1915 (b) waiver, is to require enrolled Medicaid clients to select a primary care physician/provider (PCP). Through an ongoing patient/physician relationship, the primary care provider (PCP) will provide primary care services and referrals for all necessary, specialty services that are not provided by the selected (or assigned) PCP. The PCP is responsible for monitoring the health care and utilization of non-emergency services for his/her enrollees.
Some services such as dental, family planning, vision services and supplies, and emergency services are exempt from the referral requirement.

The plan is to be continuously updated (at least annually) as quality assurance and quality improvement activities identify the need for change. There will be a bi-monthly report on waiver QA/QI activities to the HC QA/QI Oversight Committee. Any needed changes to the QA/QI plan will be approved by the committee.

An annual QA/QI review of the Healthy Connections waiver will be conducted with a report of findings; options for improvement; and recommendations to the QA/QI Oversight Committee. This includes an analysis of the QA/QI plan's effectiveness and consistency with current standards of practice for PCCM QA/QI activities.

BACKGROUND

Healthy Connections (HC) was first implemented in 1993 to improve the Medicaid delivery system in Idaho. Changes were needed to help control the escalating cost of medical care while assuring adequate access to quality health care services for Medicaid clients in Idaho. HC is a form of managed care or coordinated care and currently operates under a Primary Care Case Management (PCCM) model.

As of May 2004, 78.7% of the Medicaid population is enrolled in the Healthy Connections program. The long-term goal is for Healthy Connections to be mandatory for the majority of Medicaid participants.

HCBS WAIVER QA/QI TEAM

Statewide Waiver Quality Assurance Manager – Pamela Mason, R.N.

Responsible for:

- Coordination of the development and implementation of the statewide quality assurance plan;
- Monitoring of statewide quality assurance reports and reporting to the QA/QI Oversight Committee;
- Participation in statewide consultation and monitoring of QA/QI program
- Approval and amendments of HCBS waivers
- Development of applicable rules, policy, provider agreements, etc
- Interpretation of waiver rules, policy, implementation

Regional Medicaid Unit Managers – (RN, SW, Education)

Responsible for:

- Local implementation of Healthy Connections program;
- Local assessment and monitoring of waiver QA/QI activities;
- Implementation of plans of correction for identified deficiencies.

QA/QI Oversight Committee – Includes the Medicaid Division Administrator, Deputy Administrators, Bureau Chiefs, Regional Medicaid Managers, and Medical Director

Responsible for:

- Approval of Quality Assurance/Quality Improvement Plans

- Review of reports on QA/QI compliance and activities;
- Review of needed plans of correction;
- Decisions on plans of correction and proposed new QA/QI activities

HEALTHY CONNECTIONS QUALITY ASSURANCE FOCUS AREAS AND QUALITY IMPROVEMENT ACTIVITIES FOR 2004

FOCUS AREA I – PARTICIPANT ACCESS. THE DEPARTMENT WILL HAVE POLICIES, PROCEDURES, AND PROCESSES THAT PROMOTE INDIVIDUALS HAVE ACCESS TO NEEDED SERVICES

Outcomes

- Participants have 24 hour, 7 days per week availability to information, referral and treatment of medical emergencies; referrals for non-emergency services; or to information on how to handle medical problems during non-office hours.

- Participants will have access within 48 hours to urgent care and within 14 days to routine care.

- Participants living in mandatory enrollment counties will have access to a PCP.

Assurance/Improvement Activities 2004

- Regional Health Resources Coordinators will make 24/7 regarding after hours monitoring calls to all providers twice annually to assure compliance. Corrective actions will be taken as needed.

- All requests for changes/disenrollments will be monitored and recorded for tracking purposes. Reason codes for disenrollments due to excessive wait times for urgent and routine care will be tracked and reported individually by provider and statewide totals. Regional Health Resources Coordinators will monitor individual providers and take corrective actions when needed.

- The participant satisfaction survey for 2004 includes questions 24/7 availability and excessive wait times for services.

- The Division will track complaints regarding access issues in a Department wide electronic database.

FOCUS AREA II – QUALITY SERVICES.

Outcomes

- Participants will have access to specialty services when medically necessary.

- Participants have avenues to complain or report quality of care issues.

- Participants are offered a choice of providers.

- Assurance/Improvement Activities 2004

- For the calendar year 2004, participant satisfaction surveys will be conducted on a random sampling of HC participants.

- All requests for changes/disenrollments will be monitored and recorded for tracking purposes. Reason codes for disenrollments perceived quality of care issues will be tracked and reported individually by provider and statewide totals. Regional Health Resources Coordinators will monitor individual providers and take corrective actions when needed. Statewide trends will be tracked and reported to the Quality Oversight Committee annually with any recommendations for actions

- The Division will investigate all quality of care complaints and take appropriate action when needed. The QA Manager will report trends and any recommendations for program changes to the Quality Oversight Committee on an annual basis.

FOCUS AREA III – PROVIDER CAPACITY. THE DEPARTMENT WILL HAVE POLICIES, PROCEDURES, AND PROCESSES THAT PROMOTE SUFFICIENT CAPACITY OF HC PROVIDERS.

Outcomes

- All mandatory enrollment counties will have sufficient providers to provide medical homes for all eligible Medicaid participants residing in the mandatory county.

- Assurance/Improvement Activities 2004

- Memorandums of Participation are maintained in mandatory counties to assure that all eligible participants have access to a HC provider

- All new Medicaid PCPs are approached for recruitment into the HC program

- The Division will investigate all access to care complaints and take appropriate action when needed. The QA Manager will report trends and any recommendations for program changes to the Quality Oversight Committee on an annual basis.